PATIENT HISTORY FOR MATERNAL SERUM TESTING

The information below is required to perform the maternal serum testing.
Please attach paper requisition or include with manifest if you order electronically.

Client Location: ________________________ Specimen Collection Date:______________________

Patient Last Name ______________________ First Name _______________________ MI______

Date of Birth___________________________ Phone # ____________________________________

Physician/Genetic Counselor ____

Comments or Special Instructions and DX Code ____

☐ **QDSCR (Prenatal Risk Quad Screen)**
Must be drawn between 14 weeks, 0 days and 22 weeks, 6 days

☐ **MSSEQ1 (Maternal Screen Sequential, Spec #1, 1st Trim)**
Must be drawn in first trimester with a crown rump length between 42mm - 85mm

☐ **MSINT1 (Maternal Screen, Integrated Specimen #1)**
Must be drawn in the first trimester with a crown rump length between 36mm and 85mm

☐ Serum only, NT measurement not done

☐ **MSSFT (Maternal Screen, First Trimester Only)**
Must be drawn in first trimester with a crown rump length between 42mm and 85mm

☐ **MSSS2 (Maternal Screen, Sequential, Spec #2, 2nd Trim)**
Must be drawn between 15 weeks, 0 days and 22 weeks, 6 days)

☐ **MSSIS2 (Maternal Screen ,Integrated Specimen #2)**
Must be drawn between 15 weeks, 0 days and 22 weeks, 6 days

☐ Serum only, NT measurement not done

REQUIRED PATIENT INFORMATION:

A. Gestational Age: Weeks ______ Days ______ On (date)_____________
Determined by: LMP Date:_______ Ultrasound Date:________ EDD:_______

B. Is patient insulin dependent diabetic?
☐ No ☐ Yes

C. Current weight ______________lbs.

D. Patient's Race?
☐ Caucasian ☐ Black ☐ Hispanic ☐ Asian ☐ Other

E. Has the patient had a previous pregnancy with a chromosome abnormality? (Down syndrome, Trisomy 18 or 13)
☐ No ☐ Yes If yes, specify abnormality ___________________________

F. Is there a family history of neural tube defect?
☐ No ☐ Yes If yes, relationship to fetus? _____________________

G. Confirmed number of fetuses in this pregnancy:
☐ Singleton ☐ Twins

H. Is this an *in vitro* fertilization pregnancy using a DONOR egg?
☐ No ☐ Yes
If yes, date of birth of egg donor_____________

I. Has patient taken valproic acid or carbamazepine during this pregnancy?
☐ No ☐ Yes
If yes, specify drug ________________________________

J. Is this a repeat sample?
☐ No ☐ Yes

ADDITIONAL PATIENT INFORMATION (required for the First Trimester, Sequential, or Integrated Maternal Screen only):

Date of Ultrasound___________________________ Name of Sonographer ____

Certification # of Sonographer ________________ Reading M.D. __________________________________

NT (mm) _________________________ CRL (mm) _________________________

If twins: Twin B NT (mm) ____________________ Twin B CRL (mm)____________________

Check box if pregnancy is monochorionic ☐

Rev 5-10
#080007010050
Form # Maternal Patient History